A bill to be entitled

An act relating to Medicaid managed care; amending s. 409.908, F.S.; requiring the Agency for Health Care Administration to determine compliance with essential provider contracting requirements; requiring the agency to withhold supplemental payments under certain circumstances; amending s. 409.912, F.S.; repealing s. 409.9124, F.S., relating to managed care reimbursement; removing obsolete language related to provider service network reimbursement; amending s. 409.964, F.S.; removing obsolete language related to requiring the agency to provide public notice before seeking a Medicaid waiver; amending s. 409.966, F.S.; revising a provision related to a requirement that the agency include certain information in a utilization and spending databook; requiring the agency to conduct a single, statewide procurement and negotiate and select plans on a regional basis; authorizing the agency to select plans on a statewide basis under certain circumstances; specifying the procurement regions; removing obsolete language related to prepaid rates and an additional procurement award; making conforming changes; amending s. 409.967, F.S.; removing obsolete language related to certain hospital contracts; requiring the agency to test provider

network databases to confirm that enrollees have timely access to all covered benefits; removing obsolete language related to a request for information; authorizing plans to reduce an achieved savings rebate under certain circumstances; classifying certain expenditures as medical expenses; amending s. 409.968, F.S.; removing obsolete language related to provider service network reimbursement; amending s. 409.973, F.S.; providing for dental services benefits; requiring healthy behaviors programs to address tobacco use and opioid abuse; removing obsolete language related to primary care appointments; requiring managed care plans to establish certain programs to improve dental health outcomes; requiring the agency to establish performance and outcome measures; removing a requirement to provide dental benefits separate from the Medicaid managed medical assistance program; amending s. 409.974, F.S.; establishing numbers of regional contract awards in the managed medical assistance program; amending s. 409.975, F.S.; requiring the agency to assess managed care plan compliance with certain requirements at least quarterly; specifying that certain cancer hospitals are statewide essential providers; establishing

certain payments for such cancer hospitals; amending s. 409.977, F.S.; prohibiting the agency from automatically enrolling recipients in managed care plans under certain circumstances; removing obsolete language related to automatic enrollment and certain federal approvals; providing that children receiving guardianship assistance payments are eligible for a specialty plan; amending s. 409.981, F.S.; specifying the number of regional contract awards in the long-term care managed care plan; making a conforming change; amending s. 409.906, F.S.; conforming a cross-reference; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (26) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency

considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid-eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(26) The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments and Low Income Pool Program payments, including federal matching funds. Funds

received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by intergovernmental transfers, and in addition to any other applicable requirements, essential providers identified in paragraph s. 409.975(1)(a) ~~s.~~

~~409.975(1)(a)2.~~ must have a network ~~offer to~~ contract with each managed care plan in their region and essential providers identified in paragraph s. 409.975(1)(b) ~~s. 409.975(1)(b)1. and 3.~~ must have a network ~~offer to~~ contract with each managed care plan in the state. Before releasing such supplemental payments, ~~in the event the parties have not executed network contracts,~~ the agency shall determine whether such contracts are in place and ~~evaluate the parties' efforts to complete negotiations. If such efforts continue to fail, the agency must~~ withhold such supplemental payments beginning no later than January 1 of each fiscal year for essential providers without such contracts in place ~~in the third quarter of the fiscal year if it determines that, based upon the totality of the circumstances, the essential provider has negotiated with the managed care plan in bad faith. If the agency determines that an essential provider has negotiated in bad faith, it must notify the essential provider at least 90 days in advance of the start of the third quarter of the fiscal year and afford the essential provider hearing rights in accordance with chapter 120~~.

Section 2. Subsection (1) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are

effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. s. 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy

management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network.

The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(1) The agency may contract with a provider service network, which must ~~may~~ be reimbursed on a ~~fee-for-service or~~ prepaid basis. Prepaid provider service networks shall receive per-member, per-month payments. ~~A provider service network that does not choose to be a prepaid plan shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of the plan's operation or until the contract year beginning September 1, 2014, whichever is later. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service in the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period shall be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not~~

~~reported within the reconciliation for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation shall be considered final.~~

(a) A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641 but must comply with the solvency requirements in s. 641.2261(2) and meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency.

(b) A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other

health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

Section 3. Section 409.9124, Florida Statutes, is repealed.

Section 4. Section 409.964, Florida Statutes, is amended to read:

409.964 Managed care program; state plan; waivers.—The Medicaid program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The agency shall apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program. ~~Before seeking a waiver, the agency shall provide public notice and the opportunity for public comment and include public feedback in the waiver application. The agency shall hold one public meeting in each of the regions described in s. 409.966(2), and the time period for public comment for each region shall end no sooner than 30 days after the completion of the public meeting in that region.~~

Section 5. Paragraph (f) of subsection (3) of section 409.966, Florida Statutes, is redesignated as paragraph (d), and subsection (2), paragraphs (a), (d), and (e) of subsection (3), and subsection (4) of that section are amended to read:

409.966 Eligible plans; selection.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select a limited number of eligible plans to participate in the Medicaid program using invitations to negotiate in accordance with s. 287.057(1)(c). At least 90 days before issuing an invitation to negotiate, the agency shall compile and publish a databook consisting of a comprehensive set of utilization and spending data consistent with actuarial rate-setting practices and standards for at least the most recent 24 months ~~3 most recent contract years consistent with the rate-setting periods~~ for all Medicaid recipients by region ~~or county~~. The source of the data in the report must include ~~both historic fee-for-service claims and~~ validated data from the Medicaid Encounter Data System. The report must be available in electronic form and delineate utilization use by age, gender, eligibility group, geographic area, and aggregate clinical risk score. The agency shall conduct a single, statewide procurement, shall negotiate and select plans on a regional basis, and may select plans on a statewide basis if deemed the best value for the state and Medicaid recipients. Plan selection ~~separate and simultaneous procurements~~ shall be conducted in each of the following regions:

(a) Region A, which consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties.

(b) Region B, which consists of Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia Counties.

(c) Region C, which consists of Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties.

(d) Region D, which consists of Brevard, Orange, Osceola, and Seminole Counties.

(e) Region E, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

(f) Region F, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.

(g) Region G, which consists of Broward County.

(h) Region H, which consists of Miami-Dade and Monroe Counties.

~~(a) Region 1, which consists of Escambia, Okaloosa, Santa Rosa, and Walton Counties.~~

~~(b) Region 2, which consists of Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington Counties.~~

~~(c) Region 3, which consists of Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.~~

~~(d) Region 4, which consists of Baker, Clay, Duval,~~

~~Flagler, Nassau, St. Johns, and Volusia Counties.~~

~~(e) Region 5, which consists of Pasco and Pinellas Counties.~~

~~(f) Region 6, which consists of Hardee, Highlands, Hillsborough, Manatee, and Polk Counties.~~

~~(g) Region 7, which consists of Brevard, Orange, Osceola, and Seminole Counties.~~

~~(h) Region 8, which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota Counties.~~

~~(i) Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie Counties.~~

~~(j) Region 10, which consists of Broward County.~~

~~(k) Region 11, which consists of Miami-Dade and Monroe Counties.~~

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

7. Evidence that an eligible plan has obtained signed contracts or written agreements ~~or signed contracts~~ or has made substantial progress in establishing relationships with providers before the plan submits ~~submitting~~ a response.

8. Comments submitted in writing by any enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with any other eligible plan that responds to the invitation to negotiate.

~~(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.~~

~~1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.~~

~~2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the prior year.~~

~~(e) To ensure managed care plan participation in Regions 1 and 2, the agency shall award an additional contract to each plan with a contract award in Region 1 or Region 2. Such contract shall be in any other region in which the plan submitted a responsive bid and negotiates a rate acceptable to the agency. If a plan that is awarded an additional contract~~

~~pursuant to this paragraph is subject to penalties pursuant to s. 409.967(2)(i) for activities in Region 1 or Region 2, the additional contract is automatically terminated 180 days after the imposition of the penalties. the plan must reimburse the agency for the cost of enrollment changes and other transition activities.~~

(4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that participates in an invitation to negotiate ~~in more than one region~~ and is selected ~~in at least one region~~ may not begin serving Medicaid recipients in any region ~~for which it was selected~~ until all administrative challenges to procurements required by this section to which the eligible plan is a party have been finalized. If the number of plans selected is less than the maximum amount of plans permitted in the region, the agency may contract with other selected plans in the region not participating in the administrative challenge before resolution of the administrative challenge. For purposes of this subsection, an administrative challenge is finalized if an order granting voluntary dismissal with prejudice has been entered by any court established under Article V of the State Constitution or by the Division of Administrative Hearings, a final order has been entered into by the agency and the deadline for appeal has expired, a final order has been entered by the First District Court of Appeal and the time to seek any available review by the Florida Supreme Court has expired, or a final order has been

entered by the Florida Supreme Court and a warrant has been issued.

Section 6. Paragraphs (c) and (f) of subsection (2) and paragraph (b) of subsection (4) of section 409.967, Florida Statutes, are amended, and paragraph (k) is added to subsection (3) of that section, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) Access.—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. ~~A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1,~~

~~2013, and a final order has issued in any civil or administrative challenge.~~ Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have timely access to all covered benefits ~~behavioral health services~~.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible

to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and

followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

(f) Continuous improvement.—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

2. Each plan must collect and report the Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the agency. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment under s. 409.977 and 409.984.

~~4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.~~

(3) ACHIEVED SAVINGS REBATE.—

(k) Plans that contribute funds pursuant to paragraph (4)(b) or paragraph (4)(c) may reduce the rebate owed by an amount equal to the amount of the contribution.

(4) MEDICAL LOSS RATIO.—If required as a condition of a waiver, the agency may calculate a medical loss ratio for managed care plans. The calculation shall use uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(b) Funds provided by plans to ~~graduate medical~~ education institutions to underwrite the costs of residency positions in graduate medical education programs, undergraduate and graduate student positions in nursing education programs, or student positions in any degree or technical program deemed a critical shortage area by the agency shall be classified as medical expenditures, provided that the funding is sufficient to sustain the positions for the number of years necessary to complete the program ~~residency~~ requirements and the residency or student

positions funded by the plans are actively involved in the institution's provision ~~active providers~~ of care to Medicaid and uninsured patients.

Section 7. Subsection (2) of section 409.968, Florida Statutes, is amended to read:

409.968 Managed care plan payments.—

~~(2) Provider service networks may be prepaid plans and receive per-member, per-month payments negotiated pursuant to the procurement process described in s. 409.966. Provider service networks that choose not to be prepaid plans shall receive fee-for-service rates with a shared savings settlement. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation. The agency shall annually conduct cost reconciliations to determine the amount of cost savings achieved by fee-for-service provider service networks for the dates of service within the period being reconciled. Only payments for covered services for dates of service within the reconciliation period and paid within 6 months after the last date of service in the reconciliation period must be included. The agency shall perform the necessary adjustments for the inclusion of claims incurred but not reported within the reconciliation period for claims that could be received and paid by the agency after the 6-month claims processing time lag. The agency shall provide the results of the reconciliations to the fee-for-service provider service networks~~

~~within 45 days after the end of the reconciliation period. The fee-for-service provider service networks shall review and provide written comments or a letter of concurrence to the agency within 45 days after receipt of the reconciliation results. This reconciliation is considered final.~~

Section 8. Paragraphs (e) through (bb) of subsection (1) of section 409.973, Florida Statutes, are redesignated as paragraphs (f) through (cc), respectively, subsection (3), paragraph (b) of subsection (4), and subsection (5) are amended, and a new paragraph (e) is added to subsection (1) of that section, to read:

409.973 Benefits.—

(1) MINIMUM BENEFITS.—Managed care plans shall cover, at a minimum, the following services:

(e) Dental services.

(3) HEALTHY BEHAVIORS.—Each plan operating in the managed medical assistance program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved tobacco use ~~smoking~~ cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program, which shall include, at a minimum, a focus on opioid abuse recovery. Each plan must identify enrollees who use tobacco ~~smoke~~, are morbidly obese, or are diagnosed with alcohol or substance abuse in order to establish written agreements to

secure the enrollees' commitment to participation in these programs.

(4) PRIMARY CARE INITIATIVE.—Each plan operating in the managed medical assistance program shall establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan shall:

(b) If the enrollee was not a Medicaid recipient before enrollment in the plan, assist the enrollee in scheduling an appointment with the primary care provider. If possible the appointment should be made within 30 days after enrollment in the plan. ~~For enrollees who become eligible for Medicaid between January 1, 2014, and December 31, 2015, the appointment should be scheduled within 6 months after enrollment in the plan.~~

(5) DENTAL PERFORMANCE IMPROVEMENT.—Given the effect of oral health on overall health, each plan shall establish a program to improve dental health outcomes and increase utilization of preventive dental services. The agency shall establish performance and outcome measures, regularly assess plan performance, and publish data on such measures. Program components shall, at a minimum, include:

(a) An education program to inform enrollees of the connection between oral health and overall health and preventive steps to improve dental health.

(b) An enrollee incentive program designed to increase utilization of preventive dental services. ~~PROVISION OF DENTAL~~

~~SERVICES.—~~

~~(a) The Legislature may use the findings of the Office of Program Policy Analysis and Government Accountability's report no. 16-07, December 2016, in setting the scope of minimum benefits set forth in this section for future procurements of eligible plans as described in s. 409.966. Specifically, the decision to include dental services as a minimum benefit under this section, or to provide Medicaid recipients with dental benefits separate from the Medicaid managed medical assistance program described in this part, may take into consideration the data and findings of the report.~~

~~(b) In the event the Legislature takes no action before July 1, 2017, with respect to the report findings required under paragraph (a), the agency shall implement a statewide Medicaid prepaid dental health program for children and adults with a choice of at least two licensed dental managed care providers who must have substantial experience in providing dental care to Medicaid enrollees and children eligible for medical assistance under Title XXI of the Social Security Act and who meet all agency standards and requirements. To qualify as a provider under the prepaid dental health program, the entity must be licensed as a prepaid limited health service organization under part I of chapter 636 or as a health maintenance organization under part I of chapter 641. The contracts for program providers shall be awarded through a competitive procurement process.~~

~~Beginning with the contract procurement process initiated during the 2023 calendar year, the contracts must be for 6 years and may not be renewed; however, the agency may extend the term of a plan contract to cover delays during a transition to a new plan provider. The agency shall include in the contracts a medical loss ratio provision consistent with s. 409.967(4). The agency is authorized to seek any necessary state plan amendment or federal waiver to commence enrollment in the Medicaid prepaid dental health program no later than March 1, 2019. The agency shall extend until December 31, 2024, the term of existing plan contracts awarded pursuant to the invitation to negotiate published in October 2017.~~

Section 9. Subsections (1) and (2) of section 409.974, Florida Statutes, are amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans for the managed medical assistance program through the procurement process described in s. 409.966. The agency shall select at least one provider service network for each region, if any submit a responsive bid. The agency shall procure the number of plans, inclusive of statewide plans, if any, for each region as follows:

(a) At least three plans and up to four plans for Region A.

(b) At least five plans and up to six plans for Region B.

(c) At least six plans and up to ten plans for Region C.

(d) At least five plans and up to six plans for Region D.

(e) At least three plans and up to four plans for Region E.

(f) At least three plans and up to five plans for Region F.

(g) At least three plans and up to five plans for Region G.

(h) At least five plans and up to ten plans for Region H ~~The agency shall notice invitations to negotiate no later than January 1, 2013~~.

~~(a) The agency shall procure two plans for Region 1. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) The agency shall procure two plans for Region 2. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.~~

~~(c) The agency shall procure at least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) The agency shall procure at least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(e) The agency shall procure at least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) The agency shall procure at least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) The agency shall procure at least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) The agency shall procure at least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) The agency shall procure at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) The agency shall procure at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(k) The agency shall procure at least five plans and up to~~

~~10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

If no provider service network submits a responsive bid, the agency shall procure no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in those regions where no provider service network has been selected.

(2) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider evidence that an eligible plan has obtained signed contracts or written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submits submitting a response. The agency shall evaluate and give special weight to evidence of signed contracts with essential providers as defined by the agency pursuant to s. 409.975(1). ~~The agency shall exercise a preference for plans with a provider network in which over 10 percent of the providers use electronic health records, as defined in s. 408.051.~~ When all other factors are equal, the agency shall consider whether the organization has a contract to provide

managed long-term care services in the same region and shall exercise a preference for such plans.

Section 10. Paragraphs (a) and (b) of subsection (1) of section 409.975, Florida Statutes, are amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) Plans must include all providers in the region that are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. The agency shall assess plan compliance with such requirement at least quarterly. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and

the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(46).

3. Hospitals that are trauma centers as defined in s. 395.4001(15).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with

essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. The agency shall assess plan compliance with such requirement at least quarterly. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically

complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

5. Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v).

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan. Payments for services rendered by Florida cancer hospitals that meet the criteria in 42 U.S.C. s. 1395ww(d)(1)(B)(v) shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan.

Section 11. Subsections (1), (4), and (5) of section

409.977, Florida Statutes, are amended to read:

409.977 Enrollment.—

(1) The agency shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. When a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the agency shall assign the recipient to that plan. The agency may not automatically enroll recipients in a managed medical assistance plan that has more than 45 percent of the enrollees in the region. ~~In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is still available in the region, the agency shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.~~ Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

(4) The agency shall develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the

cost in such employer-sponsored coverage. ~~Contingent upon federal approval,~~ The agency shall also enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under ~~the Florida Health Choices Program, or~~ any health exchange, to opt out. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient. The agency shall ~~seek federal approval to~~ require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(5) Specialty plans serving children in the care and custody of the department may serve such children as long as they remain in care, including those remaining in extended foster care pursuant to s. 39.6251, or are in subsidized adoption and continue to be eligible for Medicaid pursuant to s. 409.903, or are receiving guardianship assistance payments and continue to be eligible for Medicaid pursuant to s. 409.903.

Section 12. Subsection (2) of section 409.981, Florida Statutes, is amended to read:

409.981 Eligible long-term care plans.—

(2) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans for the long-term care managed care program through the procurement process described in s. 409.966. The agency shall select at least one provider service network for each region, if any provider service network submits a responsive bid. The agency shall procure the number of plans, inclusive of statewide plans, if any, for each region as follows:

(a) At least three plans and up to four plans for Region A.

(b) At least three plans and up to six plans for Region B.

(c) At least five plans and up to ten plans for Region C.

(d) At least three plans and up to six plans for Region D.

(e) At least three plans and up to four plans for Region E.

(f) At least three plans and up to five plans for Region F.

(g) At least three plans and up to four plans for Region G.

(h) At least five plans and up to ten plans for Region H.

~~(a) Two plans for Region 1. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(b) Two plans for Region 2. At least one plan must be a~~

~~provider service network if any provider service networks submit a responsive bid.~~

~~(c) At least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(d) At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.~~

~~(e) At least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(f) At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(g) At least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(h) At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

~~(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any~~

~~provider service networks submit a responsive bid.~~

~~(k) At least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.~~

If no provider service network submits a responsive bid in a region other than Region A ~~1 or Region 2~~, the agency shall procure no more than one fewer ~~less~~ than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.

Section 13. Paragraph (d) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or

prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

(d) The agency shall seek federal approval to pay for flexible services for persons with severe mental illness or substance use disorders, including, but not limited to, temporary housing assistance. Payments may be made as enhanced capitation rates or incentive payments to managed care plans that meet the requirements of s. 409.968(3) ~~s. 409.968(4)~~.

Section 14. This act shall take effect July 1, 2022.